

Facility Name & ID Number ARBOUR HEALTH CARE CENTER

0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>70</u>	Skilled (SNF)	<u>70</u>	<u>25,550</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>29</u>	Intermediate (ICF)	<u>29</u>	<u>10,585</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>848</u>	<u>92</u>		<u>940</u>	8
9	SNF/PED					9
10	ICF	<u>32,149</u>	<u>1,422</u>		<u>33,571</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,997</u>	<u>1,514</u>		<u>34,511</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.51%

D. How many bed-hold days during this year were paid by Public Aid? N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/1/88

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/1/88 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **ARBOUR HEALTH CARE CENTER** # **0034736** Report Period Beginning: **01/01/01** Ending: **12/31/01**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	129,482	24,229	6,447	160,158		160,158		160,158			1
2	Food Purchase		134,212		134,212	(26,317)	107,896	(59)	107,837			2
3	Housekeeping	95,105	24,258		119,363		119,363		119,363			3
4	Laundry	41,707	12,831		54,538		54,538		54,538			4
5	Heat and Other Utilities			58,387	58,387		58,387	1,557	59,944			5
6	Maintenance	25,144	22,301	77,047	124,492		124,492	(13,933)	110,559			6
7	Other (specify):*							1,122	1,122			7
8	TOTAL General Services	291,438	217,831	141,881	651,150	(26,317)	624,834	(11,313)	613,521			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	1,041,348	14,297	5,176	1,060,821		1,060,821	(691)	1,060,130			10
10a	Therapy	27,996		4,695	32,691		32,691		32,691			10a
11	Activities	62,073	3,717	4,721	70,511		70,511		70,511			11
12	Social Services	38,467		4,817	43,284		43,284		43,284			12
13	Nurse Aide Training			230	230		230		230			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,169,884	18,014	21,439	1,209,337		1,209,337	(691)	1,208,646			16
	C. General Administration											
17	Administrative	55,441		168,000	223,441		223,441	(73,014)	150,427			17
18	Directors Fees											18
19	Professional Services			13,288	13,288		13,288	1,818	15,106			19
20	Dues, Fees, Subscriptions & Promotions			18,872	18,872		18,872	(4,903)	13,969			20
21	Clerical & General Office Expenses	29,875	37,289	22,712	89,876		89,876	17,838	107,714			21
22	Employee Benefits & Payroll Taxes			211,066	211,066	26,317	237,383		237,383			22
23	Inservice Training & Education											23
24	Travel and Seminar			872	872		872	(178)	694			24
25	Other Admin. Staff Transportation			314	314		314	2,694	3,008			25
26	Insurance-Prop.Liab.Malpractice			50,438	50,438		50,438	1,492	51,930			26
27	Other (specify):*							9,396	9,396			27
28	TOTAL General Administration	85,316	37,289	485,562	608,167	26,317	634,484	(44,857)	589,627			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,546,638	273,134	648,882	2,468,654		2,468,654	(56,861)	2,411,793			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,463	7,463		7,463	133,390	140,853			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,782	2,782		2,782	154,169	156,951			32
33	Real Estate Taxes			91,250	91,250		91,250		91,250			33
34	Rent-Facility & Grounds			282,201	282,201		282,201	(273,278)	8,923			34
35	Rent-Equipment & Vehicles			2,234	2,234		2,234	5,494	7,728			35
36	Other (specify):*											36
37	TOTAL Ownership			385,930	385,930		385,930	19,775	405,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,203	54,203		54,203		54,203			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,546,638	273,134	1,089,015	2,908,787		2,908,787	(37,086)	2,871,701			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	60,058	30		9
10	Interest and Other Investment Income	(10,674)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(759)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(580)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,129)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,142)	20		28
29	Other-Attach Schedule	(23,704)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 13,011		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(50,097)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,097)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (37,086)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
		Reference	
1	Miscellaneous Income	\$ (345) 21	1
2	Political Contributions - ICCLTC	(2,287) 20	2
3	Bank Charges	(397) 21	3
4	Capitalized Repairs & Maintenance	(20,275) 6	4
5	Missing Seminar Invoices	(563) 24	5
6	2001 Legal Fees	168 19	6
7			7
8			8
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90			90
91			91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ARBOUR HEALTH CARE CENTER# 0034736

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(59)											(59)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,557									1,557	5
6	Maintenance	(20,275)		1,080	5,262								(13,933)	6
7	Other (specify):*				1,122								1,122	7
8	TOTAL General Services	(20,334)		2,637	6,384								(11,313)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(691)									(691)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs			(691)									(691)	16
	C. General Administration													
17	Administrative			18,163	(91,177)								(73,014)	17
18	Directors Fees													18
19	Professional Services	168		1,650									1,818	19
20	Fees, Subscriptions & Promotions	(5,009)		106									(4,903)	20
21	Clerical & General Office Expenses	(10,633)		28,471									17,838	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(565)		387									(178)	24
25	Other Admin. Staff Transportation			2,694									2,694	25
26	Insurance-Prop.Liab.Malpractice			1,492									1,492	26
27	Other (specify):*			5,253	4,143								9,396	27
28	TOTAL General Administration	(16,039)		58,216	(87,034)								(44,857)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,373)		60,162	(80,650)								(56,861)	29

Summary B

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Arbour HCC		
				Limited Partnership	Chicago	Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **X** YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference:	
Schedule V			Line	Item	Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Mortgage Interest	\$	Arbour HCC Limited Partnership			\$ 164,843	\$ 164,843	1	
2	V	30	Depreciation		Arbour HCC Limited Partnership			73,254	73,254	2	
3	V	34	Rent Income	282,201	Arbour HCC Limited Partnership				(282,201)	3	
4	V									4	
5	V									5	
6	V									6	
7	V									7	
8	V									8	
9	V									9	
10	V									10	
11	V									11	
12	V									12	
13	V									13	
14	Total			\$ 282,201				\$ 238,097	\$ * (44,104)	14	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 1,557	\$ 1,557	15
16	V	6	REPAIRS AND MAINT.		STAY CARE MANAGEMENT, LTD.		1,080	1,080	16
17	V	10	REHABILITATION CONS.		STAY CARE MANAGEMENT, LTD.		(691)	(691)	17
18	V	17	ADMIN. SAL.-NON OWNER		STAY CARE MANAGEMENT, LTD.		18,163	18,163	18
19	V	19	PROFESSIONAL FEES		STAY CARE MANAGEMENT, LTD.		1,650	1,650	19
20	V	20	DUES, SUBSCRIPTIONS		STAY CARE MANAGEMENT, LTD.		106	106	20
21	V	21	CLERICAL & GENERAL		STAY CARE MANAGEMENT, LTD.		28,471	28,471	21
22	V	24	SEMINARS		STAY CARE MANAGEMENT, LTD.		387	387	22
23	V	25	ADMIN. STAFF TRAVEL		STAY CARE MANAGEMENT, LTD.		2,694	2,694	23
24	V	26	INSURANCE		STAY CARE MANAGEMENT, LTD.		1,492	1,492	24
25	V	27	EMPLOYEE BENEFITS		STAY CARE MANAGEMENT, LTD.		5,253	5,253	25
26	V	30	DEPRECIATION		STAY CARE MANAGEMENT, LTD.		78	78	26
27	V	34	BUILDING RENT		STAY CARE MANAGEMENT, LTD.		8,923	8,923	27
28	V	35	EQUIPMENT RENTAL		STAY CARE MANAGEMENT, LTD.		5,494	5,494	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 74,657	\$ * 74,657	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$	\$	15
16	V	6	MAINT. COMP. - NON-OWNER		STAY CARE MANAGEMENT, LTD.		5,262	5,262	16
17	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.				17
18	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.		1,122	1,122	18
19	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.		17,909	17,909	19
20	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.		58,914	58,914	20
21	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.		1,015	1,015	21
22	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.		3,128	3,128	22
23	V	30	DEPR.- AUTO - MINI VAN		STAY CARE MANAGEMENT, LTD.				23
24	V	17	MANAGEMENT FEES	168,000	STAY CARE MANAGEMENT, LTD.			(168,000)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 168,000			\$ 87,350	\$ * (80,650)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administrative	29.12%	See Attached	15	23.07%	Adm. Salary	\$ 58,914	17-7	1
2	Howard Wengrow	Owner	Administrative	26.09%	See Attached	5	7.69%	Adm. Salary	17,909	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 76,823		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER# 0034736

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

STAY CARE MANAGEMENT, LTD.

Street Address

7313 N. WESTERN AVE.

City / State / Zip Code

CHICAGO, IL. 60645

Phone Number

(773) 338-2121

Fax Number

(773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	172,882	5	\$ 7,800	\$	34,511	\$ 1,557	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	172,882	5	5,412		34,511	1,080	2
3	10	REHABILITATION CONS.	PATIENT DAYS	172,882	5	(3,462)		34,511	(691)	3
4	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	172,882	5	90,986	90,986	34,511	18,163	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	172,882	5	8,268		34,511	1,650	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	172,882	5	534		34,511	106	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	172,882	5	142,626	102,270	34,511	28,471	7
8	24	SEMINARS	PATIENT DAYS	172,882	5	1,940		34,511	387	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	172,882	5	13,498		34,511	2,694	9
10	26	INSURANCE	PATIENT DAYS	172,882	5	7,475		34,511	1,492	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	172,882	5	26,316		34,511	5,253	11
12	30	DEPRECIATION	PATIENT DAYS	172,882	5	391		34,511	78	12
13	34	BUILDING RENT	PATIENT DAYS	172,882	5	44,700		34,511	8,923	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	172,882	5	27,521		34,511	5,494	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 374,005	\$ 193,257		\$ 74,657	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER# 0034736

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

STAY CARE MANAGEMENT, LTD.

Street Address

7313 N. WESTERN AVE.

City / State / Zip Code

CHICAGO, IL. 60645

Phone Number

(773) 338-2121

Fax Number

(773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	11,983	11,983			1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	8	5,262	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,188				3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	5,610		8	1,122	4
5	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	232,813	232,813	5	17,909	5
6	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	255,296	255,296	15	58,914	6
7	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	13,197		5	1,015	7
8	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	13,554		15	3,128	8
9	30	DEPR.- AUTO - MINI VAN	AVG. HOURS WORKED	35	1	1,775				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 561,726	\$ 526,402		\$ 87,350	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Arbour HHC Ltd Partner.	X		Mortgage		1996	\$	1,830,333			\$	164,843	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6				Due on Insurance				75,996				2,782	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	1,906,329				\$	167,625	9
	B. Non-Facility Related*													
10	See Supplemental Schedule												10	
11	Interest Income											(10,675)	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(10,675)	14
15	TOTALS (line 9+line14)						\$	1,906,329				\$	156,950	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

ARBOUR HEALTH CARE CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0034736

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

(847) 236-1111

TELEPHONE

(773) 338-2121

FAX #:

(773) 338-2286

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	11-29-306-024-0000	Long Term Care Property	\$ 106,071.00	\$ 106,071.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 106,071.00	\$ 106,071.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior Brick

Frame Steel

Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1996	\$ 118,000	1
2					2
3	TOTALS			\$ 118,000	3

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	7,848		20	392	392	4,879	9
10	Various			1990	41,826		20	2,227	2,227	25,793	10
11	Various			1992	21,600		20	1,080	1,080	9,900	11
12	Various			1993	5,318		20	266	(266)	2,354	12
13	Various			1995	21,420		20	1,070	1,070	6,995	13
14	Various			1996	16,100		20	805	805	4,428	14
15	Various			1997	53,433		20	2,672	2,672	11,595	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,001,099	51,243		100,250	49,007	550,936	68
69	Financial Statement Depreciation			7,463			(7,463)		69
70	TOTAL (lines 4 thru 69)		\$ 2,168,644	\$ 58,706		\$ 108,762	\$ 49,524	\$ 616,880	70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,168,644	\$ 58,706		\$ 108,762	\$ 50,056	\$ 616,880	1
2	DAMPERS & DOORS	1998	1,316		20	66	66	220	2
3	DAMPERS	1998	1,640		20	82	82	260	3
4	DOORS	1998	1,280		20	64	64	203	4
5	WALLPAPER	1998	1,445		20	72	72	240	5
6	COX-CONSULTING	1998	2,624		20	131	131	480	6
7	COX-CONSULTING	1998	2,418		20	121	121	424	7
8	COX-CONSULTING	1998	1,100		20	55	55	188	8
9	COX-CONSULTING	1998	913		20	46	46	153	9
10	COX-CONSULTING	1998	584		20	29	29	89	10
11	PAINT & WALLPAPER	1998	1,780		20	89	89	289	11
12	TILE	2000	762		20	38	38	51	12
13	EJECTOR PUMP	2000	2,275		20	114	114	219	13
14	EJECTOR PUMP	2000	2,275		20	114	114	209	14
15	SPRINKLER	2000	863		20	43	43	72	15
16	PLUMBING	2000	760		20	38	38	60	16
17	PLUMBING	2000	648		20	32	32	51	17
18	BOOSTER	2000	801		20	40	40	70	18
19	LIGHTING	2000	3,500		20	175	175	233	19
20	IRON	2000	2,241		20	112	112	140	20
21	EXPANSION TANK	2001	680		20	28	28	28	21
22	WALLPAPER	2001	3,000		20	125	125	125	22
23	HANDRAILS, BUMPERS	2001	2,726		20	102	102	102	23
24	HANDRAILS, BUMPERS	2001	1,350		20	45	45	45	24
25	WALLPAPER	2001	6,290		20	236	236	236	25
26	BORDER	2001	1,205		20	35	35	35	26
27	CORNICE	2001	1,590		20	33	33	33	27
28	WALLCOVERING	2001	2,440		20	102	102	102	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,217,150	\$ 58,706		\$ 110,929	\$ 52,223	\$ 621,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1996		\$ 1,995,443	\$ 51,165	20	\$ 99,772	\$ 48,607	\$ 548,746	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Staycare			1992	3,485	78	20	174	96	1,712	9
10	Allocation from Staycare			2000	2,171		20	304	304	478	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,001,099	\$ 51,243		\$ 100,250	\$ 49,007	\$ 550,936	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 296,035	\$ 22,089	\$ 29,568	\$ 7,479	10	\$ 167,001	71
72	Current Year Purchases	4,856		356	356	10	356	72
73	Fully Depreciated Assets	9,845				10	9,845	73
74								74
75	TOTALS	\$ 310,736	\$ 22,089	\$ 29,924	\$ 7,835		\$ 177,202	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,645,886	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,795	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,853	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 60,058	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 798,439	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Stay Care			8,923			5
6								6
7	TOTAL				\$ 8,923			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 7,728 Description: TV lease \$2234; Allocation from Staycare \$5494
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. <u>CLASSROOM PORTION:</u> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER AIDE _____	3. <u>CLINICAL PORTION:</u> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	--	--

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$ 230	\$	\$ 230
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 230	\$	\$ 230
10	SUM OF line 9, col. 1 and 2 (e)	\$	230		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 546,709	\$ 546,709	1
2	Cash-Patient Deposits	29,172	29,172	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	752,760	752,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,918	103,918	6
7	Other Prepaid Expenses	375	375	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	100	100	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,433,034	\$ 1,433,034	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		118,000	13
14	Buildings, at Historical Cost		1,995,443	14
15	Leasehold Improvements, at Historical Cost	128,268	128,268	15
16	Equipment, at Historical Cost	47,180	294,680	16
17	Accumulated Depreciation (book methods)	(74,335)	(567,978)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 101,113	\$ 1,968,413	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,534,147	\$ 3,401,447	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 57,953	\$ 57,953	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,686	33,686	28
29	Short-Term Notes Payable	75,996	75,996	29
30	Accrued Salaries Payable	61,461	61,461	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,043	2,043	31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,600	110,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation	13,795	13,795	34
35	Federal and State Income Taxes	9,121	9,121	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	8,773	8,773	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 373,428	\$ 373,428	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,830,333	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,830,333	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 373,428	\$ 2,203,761	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,160,719	\$ 1,197,686	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,534,147	\$ 3,401,447	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 758,751	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 758,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	599,968	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(198,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 401,968	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,160,719	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER

0034736

Report Period Beginning: 01/01/01

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,497,733	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,497,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,674	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,674	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	348	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 348	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,508,755	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	651,150	31
32	Health Care	1,209,337	32
33	General Administration	608,167	33
	B. Capital Expense		
34	Ownership	385,930	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,908,787	40
41	Income before Income Taxes (line 30 minus line 40)**	599,968	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 599,968	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER# 0034736

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,016	2,080	\$ 59,782	\$ 28.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,628	16,629	338,417	20.35	3
4	Licensed Practical Nurses	13,978	15,195	275,235	18.11	4
5	Nurse Aides & Orderlies	40,616	44,645	352,249	7.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,165	3,696	27,996	7.57	8
9	Activity Director	1,455	1,648	15,898	9.65	9
10	Activity Assistants	6,807	6,847	46,175	6.74	10
11	Social Service Workers	3,952	5,352	38,467	7.19	11
12	Dietician					12
13	Food Service Supervisor	1,707	1,794	27,880	15.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,896	13,722	101,602	7.40	15
16	Dishwashers					16
17	Maintenance Workers	2,194	2,512	25,144	10.01	17
18	Housekeepers	13,898	15,157	95,105	6.27	18
19	Laundry	5,967	6,467	41,707	6.45	19
20	Administrator	1,971	2,080	55,441	26.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,507	4,196	29,875	7.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,049	1,207	15,665	12.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,806	143,227	\$ 1,546,638 *	\$ 10.80	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,447	01-03	35
36	Medical Director	Monthly	1,800	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,144	10-03	39
40	Physical Therapy Consultant	41	2,253	10a-03	40
41	Occupational Therapy Consultant	44	2,442	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	89	4,721	11-03	44
45	Social Service Consultant	91	4,817	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	265	\$ 27,656		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number		ARBOUR HEALTH CARE CENTER		STATE OF ILLINOIS				Page 23
		#	0034736	Report Period Beginning:	01/01/01	Ending:	12/31/01	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

Illinois Council on LongTerm Care \$5396

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

4,251

Line

10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$

54,203

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

26,317

Has any meal income been offset against related costs?

Indicate the amount.

\$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% In 1

d.

Have vehicle usage logs been maintained?

N/A

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

If no, please explain.

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees

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